QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
1.01 Partial	Graffiti in all areas of the facility, especially on windows or Plexiglas. The graffiti reflected extensive scratch marks, profanity, and vulgar pictures.	Lexan for some areas have been cut out and will be installed. More Lexan will be ordered for the remaining areas.	Darren Hill R. Williams J. Vinson	7-28-99	
	Many areas still in need of painting. Ceilings, the top of walls, and stairwells had peeling or chipped paint.	Painting supplies have been purchased. Pods will be painted. Maintenance has already started painting doors and columns. Maintenance will continue with building faces and office areas.	Darren Hill R. Williams J. Vinson	7-24-99	
	A ceiling in one unit had eroded due to a leak and was replaced with plywood. Standing water was noted in some of the youths' rooms.	Repaired 7-22-99. Repaired roof leak that caused the damage on 7-14-99.	J. Vinson	7-14-99	7-22-99
	Outdoor urinals on basketball courts were inoperable, filthy, and had a strong, offensive odor.	All outdoor urinals have been removed.	Darren Hill R. Williams J. Vinson	7-28-99	7-28-99
	Furnishings, especially tables in the units, were in need of repair or replacement.	Damaged table tops will be replaced by new tops by 8-6-99. If needed, additional tops will be ordered and installed.	J. Vinson D. White		
	Several doors and locks were found to be in a state of disrepair as well.	All cell locks were repaired. A memo was sent to the Chief of Security advising all staff to keep doors closed so youth will not be able to tamper with the locks.	J. Vinson	7-7-99	7-8-99
1.02	The maintenance department had	A new work order form	Darren Hill	7-28-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
Partial	over 200 work orders that had not been completed. Many of the work orders were very old, with six being dated in February and March. There were many duplicate requests for repairs found in the pending work orders. It was apparent that many repairs requested in the work orders had been completed, but it was also evident that work orders had not been completed for items needing repair.	consisting of a triplicate copy form where the unit manager discovering any repairs needed would fill out the form, keep a copy in a binder on that unit/area, forward the remaining two copies to maintenance. Maintenance will then address and repair the issue(s) discovered. Upon completion of the necessary repairs, the maintenance technician will then document the repairs performed in the work order binder on the unit/area. The maintenance technician will also document the repairs on the other two copies that were forwarded to the maintenance department. One copy will be kept by the maintenance supervisor for record keeping and the other copy will be forwarded to the AFA-Operations.	R. Williams J. Vinson		
1.04 N/C	Outdoor urinals on basketball courts were filthy and not functional, containing cups, candy wrappers, milk cartons, and standing urine.	All outdoor urinals have been removed.	Darren Hill R. Williams D. White J. Vinson	7-28-99	7-28-99
2.01	Staff interviews indicate a general lack	The mission statement and the	R. Sullivan	8-2-99	8-8-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
Partial	of understanding related to the facility's mission. Many of the staff could relate the phrase "prevent the next victim" from the facility mission statement, but could not identify the other mission elements as to how the next victim would be prevented.	code of conduct is posted on all units and training will be provide at all unit meetings during the week of August 2-8, 1999.	R. Columbo P. Jones D. White R. Cunningham		
2.02 Partial	The facility directors have not developed written, program specific goals and objectives relative to quality improvement initiatives. However, a corrective action plan in response to the last Quality Assurance Peer Review was in place. The compliance officer provided copies of memoranda showing periodic status reviews and updates at intervals shorter than six months. Just prior to the current interim facility administrator assuming her responsibilities, a "60 Day Plan" was implemented. The plan identified many actions to be accomplished by June 14, 1999.	The East Region Operations Director has completed this task.	D. Brooks	7-23-99	7-30-99
2.05 Partial	Interviews and review of documents indicate that supervisor staff meetings with line staff were infrequently accomplished or documented.	Administrative staff meet weekly as do all departments. Line staff meet bi-weekly. Full staff meetings are held once per month. The first full staff meeting was held on 7-9-99 and 7-12-99. Minutes and	R. Sullivan R. Columbo P. Jones D. White R. Cunningham	7-9-99	On Going

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
		agendas are kept and are available for review of all meetings.			
2.06 Partial	While the mechanics of reviewing policies met the requirements, numerous policies did not address required issues or procedures. In addition, staff generally reported that a copy of the FOP's was available in their unit but not always accessible. If procedural issues arose, staff reported that they consistently turned to other resources for guidance because the FOP's were generally not accessible.	A copy of the FOP, Unit Procedures, DJJ Standards, Memo Book and Book of Meeting Minutes will be placed on all dorms. Staff will be required to read, review, sign and date.	D. Brooks G. Petz D. Hill R. Williams	7-29-99	8-6-99
2.08 N/C	During interviews, youth claimed that they had been physically abused and had not been allowed to report their allegations to the Florida Abuse Registry Hotline. The review team facilitated action by the program, which led to nine youth calling the abuse hotline, while the team was on site. Of the nine youth that made such allegations, six of those reports were accepted for investigation by the abuse registry. A systematic problem with the program's reporting procedures surfaced when the interim facility administrator directed subordinate	The abuse calling procedures have been changed to where youth can call the abuse registry from the case managers' office. All staff have signed an abuse calling contract regarding reporting abuse and allowing youth to report abuse. All new hires must sign this contract in pre-service training. The youth phones on the units have been programmed to allow the youth to call the abuse registry from the living unit. The staff and youth will be trained on the	D. White J. Diab	6-18-99	8-2-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	staff to have identified youth call the abuse registry with their allegations(s). An initial response of the staff resulted in the staff bringing a statement signed by the youth stating that he no longer wanted to make a call. Staff believed that if there was an allegation of abuse, but the youth would not make the report, then the duty to report allegations of abuse no longer existed. During this review, the interim facility administrator issued a memorandum to program staff that clearly stated the provider's official position regarding abuse reporting and actions required by staff. Each staff member was required to acknowledge their receipt and understanding of this memorandum.	procedures for reporting abuse or suspected abuse.			
2.11 Partial	Observations throughout the review clearly showed that staff and youth did not display respect for each other. The use of profanity was commonplace throughout the facility. Staff were observed intimidating youth by yelling and using inappropriate physical contact.	Staff continues to be disciplined for violation of ethics code through progressive discipline. Three more training classes were completed this week to teach staff how to interact with youth and the code of ethics was also reviewed to remind them of appropriate behavior.	D. Hill R. Williams M. Williams	7-29-99	8-6-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
2.13 N/C	The program did not complete a preliminary background screening on all employees prior to being hired as required by the Department's policy. The AFA-Programs was hired 3-16-99. His preliminary background screening report in his personnel file was dated 3-24-99.	The procedure of the Inspector General revised 6/99 states that people who need to be screened are those who have been previously screened and have had a break in service exceeding 90 days. The AFA-Programs worked for CARP up until the time of his employment with CSC. There was not a 90 day break in service. His preliminary screening, though not required to be reprocessed according to the IG guidelines, was in process when he began the mandatory two week training program. During this time he did not have contact with youth.	Kim Davis		
	The AFA-Operations was part of a team from an out-of-state facility of the contract provider, that was brought in to work with the staff at the PYDC. His personnel record revealed that he was subsequently hired as the AFA-Operations at PYDC on 5-10-99. There was no documentation of a preliminary background screening report in his personnel file. As of the exit conference, the Department's	The AFA-Operations was assigned to PYDC from CSC Texas as of February 23, 1999 as the result of an agreement between Secretary Bankhead and Jim Slattery, CSC President. The AFA-Operations was screened in Texas and had an NCIC report in his personnel file. At the time of the audit, the AFA-Operations	Kim Davis	6-14-99	6-18-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	Background Screening Unit had not received a request for his background screening.	contacted the personnel technician to clear up this matter with the QA lead reviewer; however, the personnel technician was hospitalized on 6-13-99 until 6-19-99. At that time the paperwork was faxed to DJJ before 5 pm on 6-18-99.			
2.19 Partial	Fiscal management and control of the program is maintained at the corporate level. The facility administrator does not participate in budget planning or budget preparation. All expenses are approved and paid at the corporate office. The facility administrator's role is limited to signing voucher requests that are forwarded off-site.	All Facility Administrators are responsible for developing their budgets. In the absence of the FA, the East Regional Director and AFA's have worked to develop the Pahokee budget with the corporate office. Faxes and staffing patterns are available for review as well as request for capital expenditures.	D. Brooks		
2.22 Partial	The program does not have a facility-wide system or plan to recognize or encourage staff to fulfill programmatic expectations. A few unit managers have individually provided recognition or certificates for their staff.	The facility now has an employee of the month committee made up of representatives of each department. Certificates were awarded to employees from each department that have gone beyond the call of duty. FA's weekly award went out starting 7-30-99. Team building	D. Brooks		

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
		has now been established as part of the program. A meeting was held with the local Junior College and information was obtained and reviewed with staff to encourage them to return to school as CSC does college reimbursement.			
3.03 Partial	Classification of youth: The FOP addressed most of the elements in this indicator. A review of documents and interviews with staff revealed that there were 7 youth classified as sex offenders currently in the program. Each of these youth were admitted and placed in a room with another offender. None of the identified sex offenders were placed in single rooms nor in an open bay sleeping area to ensure close supervision and prevent predatory activity with other youth.	Sex offenders were moved to the second floor of the orientation dorm. They do not intermix with the orientation youth. They return to their pods after wake-up and stay with their units until bedtime. Privilege time is served on E-1 for those who have late-night. We are writing this into policy. All sex offenders are now sleeping in single rooms.	D. Brooks R. Columbo	7-29-99	7-29-99
3.08 Partial	Interviews with staff indicated that preliminary physical and mental health screenings are done by admitting staff. In a review of 35 individual health care records only one record contained the required screening utilizing the Department's required	The health services administrator has put together an admissions packet for all new intakes that includes the required DJJ forms – 1. Problem List, 2. Health Education, 3. Facility Entry	R. Barnett B. Hassan	6-1-99	On Going Issue

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	screening form. The other records all contained a suicide risk assessment utilizing their corporate form.	Physical Health Screening. Monthly chart checks will be conducted by an assigned nurse who will check all new intake charts for these forms.			
3.12 N/C	A review of 30 youth case management records showed that 15 contained completed admission cards. The remaining 15 admission cards were incomplete, including one without the required photograph.	Admission files were audited for compliance. All new files had the completed admission cards. Policy is going to change to ensure copies of all admission cards are kept along with a picture of the youth in central control for informational purposes and in case of an escape.	R. Barnett		
4.06 Partial	A review of the grievance file clearly indicates that grievances are not resolved in a timely manner. While the targeted time to resolve grievances is within 14 days, grievance resolution can take up to 2 months. Interviews with youth and staff clearly indicated that the grievance system was not working. The program recognized problems with youth grievances not being addressed in a timely manner and had formed a working group to review and make recommendations for improving the grievance process. Results from this work group had not	During the work group meetings the problems were identified. The work group has 2 more meetings scheduled. These final 2 meetings will include student representatives from the teen council. Result of the work group will be formally presented as an internal action plan which will be submitted to Mr. Brooks. The action plan will be a plan for immediate implementation of revisions in staff training and procedures pertaining to student	R. Williams P. Hofacker	5-26-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	been implemented at the time of this review.	grievances.			
4.08 Partial	The program has not fully developed a correspondence list for each youth. Writing materials and two stamped envelopes are provided to those youth without sufficient money in their accounts to pay for stamps. All others pay postage for all outgoing mail. The Department's policy requires that all youth are provided postage for at least 2 letters per week at the program's expense. Incoming parcels are allowed after the chief of security has confirmed the package is free of contraband. Staff and youth interviews consistently confirm that there is usually a several day delay for packages to be cleared and provided to the youth.	The correspondence lists are being updated and will be completed by 8-5-99. All youth are receiving the required two stamped envelopes per week. Mail is now passed out immediately and no later than 24 hours after receipt as new items were approved on the privilege list. The mail policy had to be changed in order to meet the standard.	D. Hill R. Barnett	8-2-99	8-5-99
4.09 Partial	Documentation provided to the team documented intermittent youth phone calls between January 20, 1999 and May 1999. Most of the phone call documentation provided started in June 1999. Although only a few youth claimed not to receive their phone calls, the documentation provided by the program staff did not support the	Phone logs are now being used on the units as required by our policy. The administrative staff are to ensure that the calls are logged and being made to make random checks.	R. Columbo P. Jones D. Hill R. Williams	7-30-99	8-6-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	youth received their phone calls.				
5.02 Partial	Tx team meetings: Documentation in reviewed files showed that the unit manager or mental health staff attended the treatment team meeting on an infrequent basis.	As of 7-8-99, mental health professionals have been assigned critical responsibilities for specific pods. Professional Services' ability to attend treatment team meetings will improve significantly and steadily.	P. Hofacker D. Hill R. Williams	7-8-99	7-8-99
	The notes of the bi-weekly treatment teams were well composed but often not completely filled out by the case manager. 6 of 30 files reviewed had either no dates on the notes or the incorrect date of the time span that the treatment team meeting was addressing. The date the actual note was composed was found on the document.	Training for all case managers is being provided by DJJ in August.	R. Barnett	8-9-99	8-23-99
5.05 Partial	A review of 30 youth files revealed that they generally signed 2 performance or treatment plans. The first plan was of "boilerplate" design, with goals that addressed issues to be completed during the orientation phase or the completion of level 1. This plan was written before completion of the needs assessment. The goals in the second plan were tailored in accordance with the needs	Professional Services has scheduled a retreat for 8-15-99 during which treatment plans for Anger Management Group and Substance Abuse Group will be defined. The treatment plans will include outcome goals as well as the steps students will need to take to achieve these goals. Anger Management Group and	R. Columbo R. Barnett	8-15-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	assessment findings. Although areas such as anger management and substance abuse were regularly identified in the needs assessment, they were not consistently addressed in the performance plan. The performance plan lacked substantive development and construction. The performance plans lacked measurable goals, clear objectives to be accomplished and targeted completion dates. Often targeted completion dates were vaguely listed as "on-going" , "as determined by his re-entry counselor" or "prior to release". 9 of 30 performance or treatment plans were signed before or on the same day as the needs assessment. One initial performance plan was not signed.	Substance Abuse Group meet for eight week duration's. During this time, each student's treatment team meets four times. Therefore, four steps toward the goals will be defined for each group. The steps will coincide with the material being presented in the group processes during that two week time block. The treatment plans will be prepared such that they can be "plugged into" the overall treatment plan, assisting case mangers and students to better understand what is expected during the eight week treatment within Professional Services.			
5.06 Partial	6 of 35 files (25%) reviewed had documented revisions to the performance plan. In 10 youth files, tx team meeting notes identified additional or new needs in areas such as assertiveness training, anger management and substance abuse treatment. These newly identified needs did not result I revisions to the youth's performance plan. Those	The East Regions Director and the AFA-Programs have taken over supervision of case managers and are reviewing case plans at random and giving input.	R. Barnett	7-29-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	revisions found in the youth's files did not contain documentation warranting revision of their performance plan.				
	Documentation such as a needs assessment or treatment team meeting notes did not support the necessity of revising performance plans. As with the initial performance plan, the revised performance plan lacked substantive development and construction.	Case Managers will receive case management training at the DJJ Academy.	R. Barnett	8-9-99	8-23-99
5.07 Partial	7 of 30 files reviewed were of youth who were in the program less than 45 days. Therefore, performance summaries were not yet required because of their length of stay. There were 57 performance summaries required for the 23 youth files reviewed. Of those, 31 of the performance summaries were not completed as required. Only 6 of 23 files reviewed had all of the required performance summaries. The performance summaries in place were well written and covered all the required areas.	Case managers have been trained and a tracking system is now in place.	R. Barnett	8-4-99	8-6-99
5.09 N/P	The program did not have a designated mental health authority until 6-2-99. On that date, a written agreement was formalized that	Mental Health Professional Donna Miller has develop a form for the purpose of tracking students who are on prescribed	D. Brooks P. Hofacker	7-26-99	On Going

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	designated the clinical psychologist, a program employee, the mental health authority. The clinical psychologist is in charge of the Professional Services Depart (PSD). The PSD addressed only a portion of the mental health and substance abuse treatment needs of the youth. Review of both mental health and health files indicated a pattern of poor communication between the psychiatric Advanced Registered Nurse Practitioner (ARNP) and the designated mental health authority. Although the clinical psychologist has been designated as the program's mental health authority, he did not seem to have any collaboration with the psychiatric ARNP prescribed medications. The designated mental health authority was usually notified of medication prescriptions and medication changes via a memorandum from the psychiatric ARNP. There was little documentation that the designated mental health authority was usually notified of medication prescriptions and medication changes via a memorandum from the psychiatric	psychotropic medications. Weekly meetings have been scheduled for the health disciplines. Representatives from medical, mental health, and psychiatry will meet each Thursday. The students listed on the tracking form will be discussed and the form updated at the weekly meeting. An initial inter-disciplinary meeting was held on 7-26-99. Currently the plan is to update case managers in writing about medication issues. If a particularly concerning case emerges, the responsible case manager will be scheduled to attend the weekly meeting. On 7-30-99, Ms. Miller implemented a "Read File" used to channel communications from Professional Services to Medical and the Psychiatrist. Via this file, Mental Health Progress Notes, psychological screenings, and psychological reports will be communicated to the other disciplines.		7-30-99	7-30-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	ARNP. There was little documentation that the designated mental health authority or the PSD was involved in a multidisciplinary team or in providing oversight for mental health services to youth. Memoranda between the psychiatric ARNP and PSD merely informed the staff of changes in medication. The mental health authority was generally unaware of the treatment orders or the psychiatric orders of the ARNP as demonstrated by a review of documents and interviews. Similarly, the youths' treatment teams, including the case managers, were not informed of changes in the youths' medication or of any possible side-effects that required their monitoring. Although the ARNP was the only on-site mental health clinician who was licensed to prescribe medication, effective communication among the multiple individuals comprising the mental health services at PYDC was lacking.				
5.11 - Partial	Despite the provision of mental health services from multiples sources, clinical supervision and other processes necessary for the provision of mental health services, the system	The corrective action plan has been addressed in part in 5.09 above. Communications from Professional Services with other disciplines has been	P. Hofacker	7-26-99	8-6-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	lacked the critical component of communication. For example, there were no formal lines of communication among the case managers, PSD and the psychiatric ARNP. Also, it was unclear if the information from the psychological assessments, test, and inventories were used except in PSD. Perhaps a more serious example of this lack of communication is a situation that occurred on the weekend immediately prior to the team's arrival. A youth carved the initial NWO in two-inch high letters on the upper portion of his arm. He was immediately taken to the medical unit for treatment. However, there was no documentation of sufficient follow-up with PSD until the review team raised it as a concern. Additionally, the case managers were not informed regarding the status of the youth while he was in the medical unit.	broadened regarding use of suicide precautions. By 8-6-99, Dr. Hofacker will implement other corrective actions for communication with case managers.			
5.15 Partial	Staff are trained in verbal crisis intervention as part of their Use of Force training. However, observations in the units documented that while some staff used verbal crisis intervention, other staff were	Staff has been trained in verbal crisis intervention. Supervisory staff will be evaluating the staff in their use and providing feedback.	M. Williams R. Williams D. Hill	7-23-99	7-30-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	yelling and using inappropriate physical contact and appeared to be intimidating youth.				
5.16 Partial	The YCW I & II's facilitate problem-solving/process groups which typically are more dynamic and require more training than didactic groups. In the problem solving groups observed, the YCW I & II's maintained order but, failed to maintain the focus of the group process. Issues dealt with on a superficial level. The didactic groups were led by the case managers. In these groups, the case manager presented a chapter form the Arise Foundation's "Secrets of Success" curriculum. The "Secrets of Success" curriculum appeared to be of such a nature that it should be administered by YCW I and IIs. Because of the nature of the two groups, the team concluded that the facilitators with the most training as group facilitators were used in the didactic groups. The least trained facilitators (YCW I and YCW IIs) were used in the most dynamic of the two types of groups, the problem-solving/process groups. The poor quality of the groups could be directly	All staff will be trained in group facilitation.	R. Columbo R. Sullivan R. Williams D. Hill	7-30-99	8-4-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	correlated to the training and experience of the facilitators.				
5.20 Partial	Policy and procedure addressed the requirements of the indicator. A sample of files of youth who had been on at least one home visit was reviewed. Use of required DJJ forms was inconsistently documented. Only the Home Visit Report and a single risk assessment was documented on the standardized form. Also, home visit reports were inconsistently completed. Documentation indicating home visits were planned two weeks in advance was not contained in the files.	Home visits will be addressed in the weekly case managers meeting on 8-4-99. Case managers will receive training at the DJJ Academy.	R. Barnett	8-4-99	8-4-99
5.21 Partial	Youth displayed pictures from home and religious drawings in their living area. The case manager's rooms contained art-work that addressed a case manager or a characteristic of a case manager that the youth the found appealing. The other areas of the unit were not decorated beyond any artwork seen during the previous year's review. Absent was any art-work or other indications of achievement such as certificates, achievement awards, or trophies that would reinforce youth's self esteem	Youth will be allowed to hang personal items and cards from home, within policy guidelines. The space limitations have been removed. Youth will be supplied art supplies during recreation. Youth artwork will be displayed throughout the facility.	R. Williams D. Hill	7-30-99	8-9-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	and demonstrate staff pride in the accomplishments of youth. General Education Diplomas were displayed in the Education Department's Building.				
6.01 Partial	The Student Handbook requires 24 days of appropriate behavior before applying for advancement. During interviews, some staff and youth reported that the point system was abandoned quite a while ago, while others were not sure. In addition, the current version of the behavior management system described in writing is only the most recent iteration in a series of behavioral values and beliefs that have been expressed at various times at PYDC. The program is now prepared to implement another system based upon a combination of cognitive and behavioral changes within a positive peer environment.	All staff and students have been trained on the new variance in programming. The privilege system has been updated and is more realistic. Dr. McKane will be providing training on the daily evaluation sheets.	R. Columbo M. Williams	7-23-99	8-2-99
6.03 Partial	Some staff and youth reported that the point system was abandoned quite a while ago, while others were not sure. Aggravating this situation was a pattern of the use of group punishment that is clearly prohibited by the Department. The FOP prohibits group punishment. However,	Teen council and staff will work together to revise the behavior management system. Locking down of entire groups is prohibited. Huddle-ups are now used to address problems and to effect change prior to any type of	R. Williams D. Hill C. Daley	7-23-99	7-23-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	the team found that "locking down" the whole unit was not an uncommon practice when only a few youth might have been the cause of a disruption of some sort.	consequence being given.			
6.06 N/P	The program routinely locks youth in their rooms as means of control. The team observed that the youth were locked in their rooms whenever there was "down-time" or no activity planned for the youth. Staff did not document regular checks of the youth locked in their rooms and the team observed that staff did not complete the checks. Additionally, room restriction reports or counseling sessions were not documented for the youth during the "lock-downs."	Locking down of youth is prohibited. The only time youth are allowed in their room is during sleep hours and to use the restroom. Teen council and staff are reviewing the 16-hour activity schedule.	R. Williams D. Hill	7-23-99	8-6-99
6.07 Partial	The disciplinary confinement unit had three different logs. The first log is a loose-leaf binder that lists by date, which youth were in disciplinary confinement. Each sheet in the binder is headed by the date and each youth is listed by name with the offense, supervisory approval, date and time in and date and time out. The second log is an alphabetized listing by the youths' last name. It too is loose-leaf binder with alphabetized	The confinement logs and procedures are being revised to ensure we are in compliance with DJJ Standards for Disciplinary Confinement.	R. Williams D. Hill D. White	8-3-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	section dividers. Each page contains one youth's name with the offense, supervisory approval, date and time in and date and time out. The third log entitled the Confinement Log is a bound conventional log with a daily chronology. Between January 1 and April 28, 1999 this log contained entries for only three dates January 28, February 24 and February 27. Staff initially explained the utilization of disciplinary confinement dropped off dramatically during this time frame. However, log one and log two, as described above, showed routine, very nearly daily use of disciplinary confinement during this period. The report lacked of disciplinary confinement as reflected in log three was not consistent with the other logs. In addition, there was another log entitled the Behavior Management Unit (BMU) log. This log contained entries for missing dates in the other logs. For examples, on an April 19 entry in the BMU log there was an entry indicating that the BMU log was incorrectly being used for disciplinary confinement entries. This April 19 entry mandated that all confinement				

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	entries would be logged in the confinement (log 3). However, it was not until April 28th, more than a week later, before there are any entries in log 3. But logs 1 and 2 document that there were seven youth placed in confinement. The confusion is representative of the confusion through-out the program concerning confinement policy and documentation requirements.				
7.03 Partial	Despite the compliance with policy, interviews with staff and youth indicated that in their evaluation, the food was prepared with little consideration of flavor, texture, and palatability. In addition, youth complained about portion sizes. Staff and youth stated that meal size increased when visitors were on-site. Another concern was the manner in which youth were served in the dining room, Eight youth at a time were seated at a table. All youth at each table waited until the last youth was seated before beginning to eat. Youth complained that the food was cold by the time they were allowed to eat. Also staff were observed collecting	On 7-27-99, there was a staff meeting with all Aramark employees informing them that all meals will be prepared one hour before meal time. All foods must be on the steam table fifteen minutes before meal time. The temperatures and weights must be taken at this time. The dinning room procedures are being revised by the Chief of Security. The procedures will be completed by 8-6-99 and training will start on 8-10-99. The procedures will allow the youth ample amount of time to consume each meal. During dinner larger	D. White V. Wallace D. Hill R. Williams	7-27-99	8-10-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	eating utensils prior to the youth finishing their meals resulting in youth completing their meals with their fingers.	portions are being served. The portion size was changed from 8 - 10 oz. to 12-15 oz.			
8.05 N/C	Policy and practice clearly documented a system for procurement and verification of medications. However, the component of parental notification was lacking. Individual health care records reviewed indicated parents are not provided with written notification if medication is prescribed or changed for their child. Health care notes contained entries indicating that parents were notified by nurses through telephone calls, but not by the psychiatric ARNP, although nurses did state that the ARNP notified the parents by phone. The program has not implemented the use of the DJJ Health Services Manual "Parental Notification of Health-Related Care" form to notify parents of newly prescribed medications or changers in the medication for their child.	Copies of DJJ's Parental Notification forms are now placed in medical form slots and are being utilized to notify parents. The nurse on duty will place the Parental Notification in the chart for the director of nursing to mail off to parents of any and all changes to the youth's medications. Communication between medical and the psychiatrist is now being done in the form of a weekly meeting.	B. Hassan P. Hofacker R. Barnett	6-1-99	On Going Issue
8.09 Partial	The program has a well-established method of medication administration. However, documentation in individual health care records reviewed did not	*See Standard 5.09* - In-service will be conducted by Dr. Adair for nurses on side –	P. Hofacker B. Hassan R. Barnett	7-30-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	reflect timely re-evaluations or monitoring of side effects for youth on psychotropic medication. Additionally, nursing staff are not informed of the potential side-effects of psychotropic medication and there was little communication between health care and mental health staff concerning youth on psychotropic medication.	effects of psychotropic medications.			
8.18 N/P	Policy and procedure is consistent with the indicator, but it is not in practice. None of the individual health care records reviewed contained a DJJ Health Education Record with entries by the program as required by the indicator, DJJ Health Services Manual, and program policy. It was reported that the only health education provided was by non-health care staff using the Arise Foundation's "Secrets of Success" curriculum. There was documentation of specific health instructions in notes recorded by nurses during health care encounters with the youth.	Medical will complete DJJ Health Education Record Sheets as youth are educated on different issues. - Nurses will document on these forms any health education given. - The H.S.A. will meet with educators once a month to present health topics as they arise.	B. Hassan R. Cunningham	6-1-99 7-20-99	On Going Issue
8.19 Partial	The Sick Call Index from is or particular concern, as it is essential for nursing staff to keep track of repeated complaints for the youth, especially given the large number of youth in the	The Sick Call Index Form is already in place and is functional. Sick Call Log is input into a computer and printed out each week.	B. Hassan	6-1-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	facility. The organization of documents within the records was confusing and inconsistent in many of the records reviewed. Chronological notes completed by nurses were thorough in cases involving emergency first aid, but were incomplete for common sick call complaints in some cases. There was little information found in the records pertaining to the youths' mental health treatment or side effects to psychotropic medications.	- All progress notes, nurses notes and sick call are filed at the end of each shift which will resolve the inconsistency of chronological filing of notes. - All sick call sheets will show subjective, objective assessments and a plan of each encounter with youth. - A no show with explanation will be noted if a youth s not seen. - A tracking sheet will be in place in the MAR about any youth on psychotropic medication that will show side effects. - Charting will be done every week on youths that are on psychotropic medications concerning their behavior and / or side effects on the tracking sheet placed in the MAR.			
9.03 Partial	Logbooks are used in each of the control centers and living units. Entries related to security and safety issues were normally highlighted. The general content of the entries	All administrative staff are required to visit each living unit at least twice a month to discuss issues with the youth and review the logbook, per Mr.	D. White D. Hill R. Williams	8-2-99	On Going Issue

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	frequently did not contain strategic information about incidents or situations to identify what had taken place. Log books did not contain documentation to show incoming supervisors and staff review the log book, nor was weekly review of the log book documented by the program director or designee.	Brooks. The staff trainer will conduct training with all staff on incident report writing and logbook entries.			
9.11 N/C	Documentation provided to the review team did not support that program staff were accounting for all eating utensils. For example, there were gaps in the documentation September 1998 through March 1999. Beginning in April 99, eating utensils were accounted for in writing.	The Food Service Supervisor and the Chief of Security will monitor cutlery sheets on a weekly basis to ensure all documentation is available and ensure we are accounting for all utensils.	D. Hill R. Williams D. White	6-18-99	On Going Issue
9.15 Partial	A review of written inventory, Use of Force Reports, or log books, did not validate or document when restraints were used. Documentation was missing or not provided for the months of October and December 1998. Reviewed reports did not document that they were completed within two hours of the incident as required nor that a review by the program director and health care staff occurred within twenty-four hours.	All staff will receive training on the procedures for completing Use of Force Reports. The AFA of Operations and the Medical Director will schedule a meeting to put a practice in place to ensure all Use of Force Reports are signed by the proper authority.	D. White	8-2-99	
9.16	The use of any type of physical	All staff will receive training on	D. Hill	8-2-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
Partial	restraint was not consistently documented in the program log book and use of force reports were not consistently being completed. Log Book entries and use of force reports usually did not provide the required information on the use and type of any physical restraint. Use of Force report entries consistently stated "refer to incident report" or "refer to witness statement." While the program's FOP states physical restraints were documented by central control in the Mechanical Restraint Log Book, the log book provided for review did not include entries of physical restraint.	where to document Use of Force Reports and how to complete a Use of Force Report. The procedures for documenting physical restraints will be revised by the Chief of Security.	R. Williams		
9.17 Partial	The program provided a list of seven off-campus community service activities in this review cycle. Of the seven activities which the program administration staff confirmed took place, a security risk classification review was provided for only one activity.	The shift supervisors and control operators have received training on notifying the Chief of Security before any youth departs the facility. This will allow the Chief of Security to ensure that any youth departing the facility has had a security classification review.	R. Barnett		
9.18 Partial	The program's FOP states that room checks will be done every 15 minutes during sleep periods, which exceeds the frequency required. However, there is no written documentation to	A new form has been created to ensure staff are doing visual checks on the safety and security of each youth. This form is currently being used in	D. White D. Hill R. Williams		

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	show that staff visually checks the safety and security of each youth. Logbook entries contain statements such as "45 youth on unit."	our daily practice.			
10.01 Partial	Policy and procedure covers all elements of the indicator, but the procedures are not being practiced. Pre-release notifications were completed 45 days prior to the youths' anticipated release date in ten or fifteen closed files reviewed, but other notifications were not completed as required. Notification of the youths' parents and travel arrangements were not consistently documented. Notification of educational staff was rarely documented or the notification was inaccurate. Exit conferences to discuss the youths' aftercare plan were not conducted 14 days prior to the youth's release. Nine of the fifteen closed files contained documentation that would be included in the aftercare plan.	The entire transition program at PYDC is being addressed. The transition specialist now is under case management. The transition specialist and case managers will attend training in August at the DJJ Academy.	R. Barnett K. Whitting R. Cunningham	8-9-99	8-26-99
10.02 Partial	Transition plans were found in only four of the fifteen closed files reviewed. The plans did not outline specific aftercare conditions, address on-going needs identified while the youth was in the program, and were	The entire transition program at PYDC is being addressed. The transition specialist now is under case management. The transition specialist and case managers will attend training in	R. Barnett K. Whitting R. Cunningham P. Hofacker	8-9-99	8-26-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	not completely filled out. Nine of the fifteen youth had transition conferences to discuss aftercare supervision requirements, but input from the youth's parent(s), assigned Juvenile Probation Officer (JPO), or aftercare provider for the conferences was very limited, if obtained at all. There was no input from educational staff, health care staff, or mental health and substance abuse counselors during the transition conferences or in the aftercare supervision plan.	August at the DJJ Academy.			
10.03 Partial	Documentation that parents, JPO's or aftercare providers were invited to transition planning conferences was found in only four of the fifteen close files reviewed. Actual conferences were held in nine of the cases, but many of these conferences were conducted with only the youth and the transition specialist. Some of the conferences included the parent, the JPO, or the aftercare provider but, not a combination of those persons. The transition specialist sent a memorandum to the Education Department and the PSD which contains a schedule of transition	The entire transition program at PYDC is being addressed. The transition specialist now is under case management. The transition specialist and case managers will attend training in August at the DJJ Academy.	R. Barnett K. Whitting	8-9-99	8-26-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	conferences. However, the schedule was found to be inaccurate and representatives from these departments neither attend nor provided input for any of the conferences.				
10.04 Partial	The program sends the youths' case records via certified mail to the youths' JPO or aftercare provider upon release from the program. However, the review team found that there were significant delays in the files being sent to the JPO or aftercare provider. Of the 15 closed files reviewed: four were mailed to the JPO or aftercare provider within two weeks; two had no record of being mailed' four were mailed at least three weeks after the youth was released; and five were pending being mailed upon receipt of the health care file. All five of the "pending" cases were for youth who had been released at least three weeks prior to the review. These delays could disrupt services for the youth and family, especially if health care information is needed on the youth.	The entire transition program at PYDC is being addressed. The transition specialist now is under case management. The transition specialist and case managers will attend training in August at the DJJ Academy.	R. Barnett	8-9-99	8-26-99
Standard Eleven : Aftercare Services were Not Applicable.					
12.01	The program has a 1999 Training	The training plan for the 1999-	R. Sullivan	8-4-99	8-4-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
Partial	Plan, which does not address the minimum training requirements for all employees. The two page plan, signed January 20, 1999, identifies a new training coordinator, and a new instructor. Some specialized training to be provided by the Clinical Director and PSD was also identified. However, the plan did not delineate minimum training requirements for all employees, training requirements for part-time employees, procedures to incorporate training mandated by the Department, or a schedule for training individual employees. The training plan provided showed two hours of specialized training for employees on suicide prevention and four hours of de-escalation techniques. Schedules for training individual employees were not accomplished.	2000 year will address the established minimum training requirements mandated by DJJ, QA and ACA for each employee, to include part-time employees. A training advisory board meeting is scheduled for 8-4-99, all department heads will submit their training plan for their department as well as an individual training plan for each employee, based on established minimum training requirements. The plan will also provide for specialized training to include but not limited to suicide prevention and case management training, by the AFA-Programs and the PSD. The training advisory board will meet quarterly to make revisions or changes to the training plan to monitor compliance with standards. All training will be documented in the employee training records, a report will be forwarded to the Facility Administrator each week on the progress and compliance of the training plan.			

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
12.02 Partial	Of 30 staff training files reviewed, 5 were of employees either completing their first year of employment or had at least nine months on the job. None of these five achieved the minimum 120 hours of training. Required DJJ Basic Training and Residential Services training were not documented in the training records reviewed for any of the first year staff.	All full time employees who work in direct and continuing contact with youth shall receive 40 hours of orientation training to include but not limited to DJJ Basic Training and Residential Services Training, the Ethics and Compliance Program, the program's mission, treatment program, emergency procedures, fire safety and equipment to include the alarm system and the egress plans, 40 hours of Use of Force training which includes, verbal crisis intervention techniques, 8 hours CPR/First Aid, 16 hours of OJT, which will be documented on a OJT training form, signed by the supervisor and submitted to the training department two weeks following orientation by the Building Superintendents to be documented in the employee training records. An additional 16 hours of in-service training on job-related topics to include but not limited to group skills, unit procedures, Arise group	R. Sullivan	8-4-99	8-4-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
		training and de-escalation techniques, to ensure each employee receives the established minimum training requirements of 120 hours for first year employees.			
12.04 Partial	Of thirty staff training files reviewed, twenty one were identified as subsequent year employees. Ten of the twenty (50%) had the required forty hours of training documented. Six of twenty (30%) did not contain documented completion of CPR and First Aid training. Three of the twenty (15%) had documentation of fire safety equipment and alarm system training.	To ensure employees receive the established minimum of 40 hours of job-related training annually, a weekly training schedule is being implemented in August to include refresher training in fire safety equipment and the alarm system, CPR/First Aid has been on going, there are currently 3 certified CPR/First Aid instructors on-site, and all employees are receiving the training. A weekly report will be forwarded to the FA regarding employees receiving their annual 40 hour job-related training for their anniversary year, or employees which are deficient of required training hours. Fifteen training files from various departments will be reviewed weekly and the report forwarded to the FA to monitor	R. Sullivan	7-1-99	8-30-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
		compliance standards.			
12.06 Partial	Training files generally contained a summary sheet of individual training completed. However, documentation to support training completion by employees was generally not contained in the training record. Occasionally training certificate or attendance sheets for training sessions were included. Certificates for Use of Force, CPR and First Aid training were consistently found in training records, other documentation was rarely present in the files.	The training files are being updated to include all relevant documentation to include, certifications, examinations, test results, syllabus' and lesson plans(if applicable), with the addition of a part-time clerical employee, the training files will be continually updated and maintained. All information include in the training records will contain the course, training hours, beginning and conclusion times of training and the trainer. A weekly review of the training records will ensure compliance and recognize deficiencies in the training records, a report will be forwarded to the FA weekly on the compliance of the training files.	R. Sullivan	7-30-99	7-30-99
12.07 Partial	Documentation for training provided on-site generally did not include lesson plans, a syllabus or summary of main points. Exceptions were noted showing that Use of Force lesson plans and a supervisory training course lesson plan were	A syllabus or lesson plan will be established for all training material. Meeting minutes, agendas, sign-in rosters, syllabus' or lesson plans for training will be forwarded to the training department within 5	R. Sullivan	7-15-99	7-15-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	provided for the team to review. The program also presented other training material used to support their training program.	working days of scheduled training by the department head or his/her designee, to be documented in the employee training records. A weekly report will be forwarded to the FA containing information regarding compliance of this standard. All department heads will immediately be forwarded a memo regarding these training requirements and time constraints.			
13.01 Partial	Weekly safety inspections did not include checking communication equipment for a vast majority of the review period. The program only recently began to include communication equipment in the weekly inspections on May 13, 1999.	A new procedure has been added to our daily practice to include checking communication equipment daily.	D. White	7-15-99	On Going Issue
13.02 Partial	Policy and procedure outlines a plan for every type of emergency required by the indicator. However, the plans for tornadoes and severe weather did not clearly outline what staff should do in the event of these emergencies. The plan for a tornado watch warning requires that youth be moved to the center of the residential area and then place their backs to the wall. These	The emergency and sever weather procedures are being revised by the Chief of Security and training is scheduled to start 8-10-99 for all departments.	D. White P. Jones	8-2-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	procedures conflict with the facility design as there is no wall for the youth to place their backs against the center of any residential area, with the exception of the control area which is surrounded by glass. The plans for hurricanes or severe weather outline the need and procedures to evacuate youth from the facility if required, but does not identify the location or shelter to which the youth are to be evacuated. Staff interviewed were not familiar with procedures outlined in the plans and youth interviews indicated that the youth are placed in their rooms during severe weather or tornado watches. The review team observed that staff were most unfamiliar with the emergency plan in the event of a fire. Staff interviewed were not able to identify evacuation routes and staff were confused and very slow to act during a fire drill observed by the review team.				
13.03 N/C	Evacuation egress plans did not accurately depict the location of fire extinguishers, first aid kits, and fire alarm pull stations. Evacuation egress plans in different areas had different color coding for fire safety	All evacuation plans were replaced with new and accurate plans that consistently depicted the location of fire extinguishers, first aid kits, and fire alarm pull stations. All fire	D. White H. Ruiz	6-14-99	6-18-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	items. For examples, a plan in one area had yellow dots for fire extinguishers and red for first aid kits while a plan in other parts of the facility had red dots for fire extinguishers and yellow dots for first aid kits. Evacuation routes were highlighted, but the highlighting was so faded on primary evacuation routes were highlighted, but the highlight was so faded on primary evacuation routes that they could not be seen.	extinguishers are depicted on the egress plans with a red dot. First aid kits are depicted using a blue dot. Fire alarm pull stations are depicted on the egress plans using a green dot. "You are Here" is depicted using a blue star. All fire hydrants are depicted on the egress plans using a red star. All evacuation plans were laminated to prevent them from fading or being tampered with and were also posted on the walls behind plexiglass.			
13.04 Partial	The fire safety log was reviewed and indicated fire drills were not conducted from September 28, 1998 to February 18, 1999. The log also contained an entry for a fire drill that was out of sequential order. The log did not contain documentation of fire safety inspections, corrective action, or periodic fire safety inspections by staff as required. When comparing the fire safety log to logs on the living units, the times for fire drills found int eh logs for the living units. Fire saftey equipment was available throughout the program, but it was not accurately	The egress plans have been revised. No fore drills will be announced. They are done at random, including high profile times. The missing fire drills were found. They had not been filed.	D. White R. Sullivan	7-1-99	7-28-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	depicted on egress plans. Living unit ~~Logbook has documentation~~ indicating that fire drills are announced beforehand at times. Staff interviews and training files reviewed indicated staff are not trained in the use of the fire safety equipment and the alarm system as required. The review team observed a fire drill during the review in which the staff appeared confused, were very slow to respond and evacuation took approximately 15 minutes.				
13.05 N/C	Fire extinguishers in the vehicles used to transport youth did not have inspection tags on them and one was found empty. The first aid kits in the van that is primarily used to transport youth was found to contain only gauze pad, gloves, and a bio-hazardous waste bag.	Replaced all extinguishers with bigger, properly tagged extinguishers. Fire extinguishers in the vehicles will be checked weekly during weekly vehicle inspection performed by maintenance beginning 8-6-99.	D. White J. Vinson	6-22-99	6-22-99
13.06 N/C	Although there was list of required items and written process to check first aid kits, the practice was not fully implemented. A first aid kit in the laundry room was not sealed and the contents had not been approved by the designated health authority as required. A first aid kit in a van contained only gauze pads, gloves,	The location of first aid kits will be posted on a list throughout the facility as well as on all egress plans. Staff will receive training by the Staff Trainer on the procedures and locations of the first aid kits. - Medical will fill any first aid kit once a request is	D. White D. Hill R. Williams B. Hassan R. Sullivan	8-4-99 6-1-99	8-4-99 7-1-99

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	and a bio-hazardous waste bag. Other first aid kits did not contain all the items that were identified as necessary by health care staff. Policy and procedure and evacuation egress plans did not accurately identify the location of first aid kits. Staff interviews revealed that many staff are not familiar with the location of the first aid kits.	received from any department. - A standard list of items is provided by medical.			
14.02 Partial	24 of 31 current student education files contained assessment information. The TABE is administered during the orientation phase of the program. Vocational assessments are not administered to students during entrance into the program. Some students are administered the CHOICES vocational assessment, though this was done inconsistently at various times during the commitment of youth. Most youth are not assessed vocationally.	Vocational assessments will be done immediately during orientation and the results of this vocational assessment will be incorporated into the student performance plan.	R. Columbo B. Holmes	8-9-99	
14.03 Partial	14 of 31 files reviewed had educational plans referred to as IPP's. The IPP's included long-term goals and short-term objectives. However, in many cases these goals were vague and general. In addition, the use of IPP's was inconsistent. Classroom	The initial IPP is initiated by the school psychologist after the student takes the TABE test. A copy of the initial TABE/IPP is given to each teacher. Each teacher reviews the initial IPP and determines future goals for	Lead Teachers	8-9-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	observations, teacher interviews, and review of IPP's indicated that some teachers used them regularly, while others were not aware of the content of the plans. Though 15 of 16 ESE files contained IEP's, there was no dated documentation that the IEP's were developed and/or reviewed within 11 days of entry.	the student to master. The teacher will use the initial IPP generated by the school psychologist and proceeding goals will be determined in conjunction with the State of Florida Sunshine Standards immediately. Teacher lesson plans will be individualized based on the IPP's. The lead teachers from each team will monitor students educational plans on a weekly basis.			
14.05 N/P	A review of 27 closed student education files revealed that exit transition information does not exist, or is not being placed into student closed files. Exit plans are not given to students upon exiting the program. Interviews and document reviews reveal that exit plans are not utilized at this program. Interviews with staff and a review of closed files indicate a lack of appropriate participation in exit transition staffing. The program administers academic post tests in some cases, but they are not used to determine future educational needs or	The guidance counselor will attend transitional meetings with the transitional specialist and written documentation in student files.	R. Cunningham St. John	8-9-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	placement. Student records are not being transferred to the next placement consistently nor typically in a timely manner.				
14.08 Partial	Instructional delivery is not based on the TABE or vocational assessments. Teacher interviews indicated that most instructors conducted their own assessments to determine individual student levels. However, this is inconsistently done. Some teachers modify the curriculum to meet the needs of ESE students. Teachers do not receive adequate ESE support, classroom space, or instructional materials which make it difficult to modify instructional delivery. Therefore, the current curriculum does not address the individual needs of students. Overall, teacher lesson plans do not reflect student educational plans or IEP's. Observations and student interviews revealed that individual academic levels and learning styles are not addressed in the classroom.	Teachers will develop their lesson plans to directly reflect the results of the TABE test. Individualized Performance Plans (IPP) and IEP's based on the TABE results. The education department will present a classroom management workshop beginning fiscal year 1999-2000. Lesson plans will be reviewed by the lead teacher/principal to ensure that the lesson plans are coordinated with their IEP's and IPP's A request has been made for additional ESE teachers. ESE teachers will work with students in their regular classroom setting where appropriate.	Lead Teachers	8-9-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
14.09 Partial	There are 2 ESE teachers and one ESE coordinator on-site, though none are ESE certified. The school district provides ESE consultation services on a limited basis, usually bi-monthly. The educational staff could only identify some students in the ESE program. Therefore, consistent ESE services are not provided to all students. English for Speakers of Other Languages (ESOL) is provided. There is an on-site mental health counselor who is able to make further psychiatric referrals if necessary. This program has a school psychologist currently in the process of professional certification. Health care services are provided on-site. However, students and staff reported the lack of prompt health care attention, such as student waiting 48 hours or more for health care services. Classroom teachers do not receive daily information regarding the status of individual student needs, such as the use of any medications. Interviews with teachers and students revealed that vision screenings are not regularly performed. Teachers reported several students appeared to	Documentation of qualifications of ESE coordinator/teacher will be file in the education administrative files. An effort will be made to recruit certified ESE teachers.	R. Cunningham	8-9-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	have severe vision impairment, yet no vision services were provided to those students. Observations of the student body revealed very few students in possession of eyeglasses.				
14.10 N/P	There is no indication that students are receiving any formal academic guidance services. Students interviewed were not able to identify who delivered guidance services. No student reported meeting with a guidance counselor to discuss abilities, aptitudes, and educational and vocational options. No one had discussed diploma options with any students interviewed. Students receive no academic guidance regarding educational or vocational options upon exit from the program. The guidance counselor does not provide input regarding students next educational placement.	There will be a cooperative and collaborative relationship between the guidance counselor and the transition specialist for all services/activities provided to the students. The guidance counselor and transition specialist will coordinate and communicate their respective roles and functions so as to enhance the maximum services and activities available as opportunities for each student. Both the guidance counselor and the transition specialist will examine the education standards for their respective service areas provided and make recommendations to the assistant principal to ensure PATCH's compliance. The guidance counselor and the transition specialist will meet with the assistant	R. Cunningham St. John K. Whiting	8-2-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
		principal to review their respective job description, discuss role, function, services and activities to be provided to our students as well as to ensure satisfactory compliance with the educational standards. Will develop a "Request for Guidance/Transition Services Form" to be easily and readily accessible to all students at any time in order for the student to request an appointment with the guidance counselor or the transition specialist. Will develop a checklist for the guidance counselor, transition specialist, teachers and staff to utilize when discussing guidance or transition services, the student's educational status, or transition services available to the student at orientation, at any time during confinement, and prior to exiting form the program. The checklist will serve as a log for Q.A. purposes and assist in providing goals and outcomes			

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
		for each student and this form will be placed in the student's file. Students in orientation will be given a copy of their educational credits.			
14.11 Partial	The program had limited documented community support. This support includes occasional guest speakers, and student building and donating furniture to local groups and churches. A review of documents indicated that most community volunteers involved with the program conduct church services. There were no community support services such as volunteer tutoring, career days, and business partnerships that would reduce isolation from the community and involve the community in the student's education.	A committee has been established and is currently working on scheduling two career days for the students at PYDC. The committee will also recruit/invite guest speakers.	R. Cunningham A. Berry	8-2-99	
14.12 Partial	The curriculum was aligned with the Florida Sunshine State Standards (FSSS) and benchmarks. Individuals delivering services to students have knowledge of the FSSS, benchmarks, and their inclusion into the district curriculum. This was confirmed by a review of teacher lesson plans. However, teacher course assignments	Teachers will be assigned to their areas of certification or the area they are seeking certification for. All education in-services will be documented. All teachers are required to maintain information regarding the GED Diploma Option, the	R. Cunningham	8-9-99	

			Person Responsible	Date Started	Date Completed
	are changed on a regular basis. revealed many teachers are not teaching on their area of expertise. Most of the teachers were not fully certified but held Statements of Eligibility. Most of the vocational instructors were not certified (Refer to E:3.05). There was a little indication of curriculum modification for all students, including those with disabilities. Most teachers are knowledgeable of high school graduation requirements, including state and district-wide assessments. However, it is unclear if teachers are familiar with high school graduation requirements and GED diploma options.	Certification of Attendance Option, and the Regular Diploma Option in their students' working copy file. Teachers will be required to sign a document indicating they have complied with this requirement. Vocational teachers will be required to complete 6 credit hours per year towards certification. Curriculum modifications will be made for all students including students with disabilities.			
14.13 N/P	There are currently no guidance services provided to students on a formalized basis. Students are not aware of the guidance services available to them. Therefore, students are not knowledgeable of course credits, career and vocational opportunities, or available re-entry educational placements.	All teachers are required to sign and acknowledge that they have read, received and understand the High School Promotional Information Sheet regarding Graduation Requirements. This form will be placed in the teacher's handbook. All teachers will be required to	R. Cunningham	8-2-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
		sign for the new handbook. This form will also become part of the new students orientation. Each teacher is also required to insert a copy of the graduation requirements form in their students' folder. All teachers will be given a copy of the requirements for graduation form at the initial pre-service staffing development meeting on 8-13-99 and will be required to sign an acknowledgment form indicating receipt of the graduation requirement form and that they are responsible for including this form in each students' folder.			
14.14 Partial	Some teachers are using the objectives and strategies contained in educational plans for non -ESE students. However, objectives and strategies noted in IEPs for students in ESE are not implemented on a regular basis due to a lack of adequate ESE support personnel. The district ESE consultant does not provide regularly scheduled services to this program. Individual instruction	A split schedule will be formulated to resolve the problem with the lack of classroom space.	R. Cunningham D. Brooks D. White St. John	7-30-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	is limited due to a lack of instructional resources available to teachers. Instructional strategies are also limited due to students arriving late to class and behavioral problems occurring during class time. Classroom space is not adequate and many teachers have to share instructional space. There are no instructional aides available.				
14.15 Partial	Classroom management is deficient. Teachers do not have the appropriate number of support staff to effectively provide an environment that is conducive to learning. Although teacher to student ratios vary from approximately 1:4 to 1:20, during our visit interviews and student observations revealed an overall disruptive atmosphere in the facility that is regularly brought into the classrooms. Many students reported incidents of abuse and harassment by facility staff. Students appeared to be anxious, frustrated, and angry during class time. Observations revealed students cursing at teachers and many not paying attention or doing their work during class. Teachers interviewed had no knowledge of policies and procedures in place for	The school district and the PSD department will provide training regarding working with diverse populations.	R. Cunningham P. Hofacker	8-2-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	effective behavior management within the classroom. While some students confirmed they learned about cultural diversity in classes such as history, the curriculum as a whole is not multi-cultural.				
14.16 Partial	Individuals delivering educational services to students in the academic subjects are certified of eligibility. However, only one of six vocational teachers had a statement of eligibility. A review of teacher files revealed that all staff received a professional development plan. However, documentation showing staff input or utilization of these plans did not exist. Some teachers have many years experience, while others are new teachers. Only one of six vocational teachers had a statement of eligibility from PBCSB. The other vocational instructors did not have the required school district approval.	At least twice per year all education employees will be required to document all credits earned towards temporary or permanent certification. DOE will forwarded a copy of all such documentation.	R. Cunningham	7-30-99	
14.17 Partial	Teachers have weekly staff meetings that are occasionally attended by facility administrators. However, educational staff do not attend facility or program meetings with program administrators. The acting principal was appointed one month ago by the	Teachers now attend the full staff meetings held once a month. Administrators attend the educational staff meetings. Teachers have been divided up into working teams to develop the corrective action plan for	R. Cunningham	7-14-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	school district on an interim basis. Staff has not been involved in the educational program planning. The faculty have been informed of a transition to block scheduling, yet there was no faculty input or preparation for this important transition. Teachers are uncertain of their roles during this transition and unsure of the purpose and use of IPPs.	QA in education.			
14.18 Partial	There is currently no formal program evaluation that takes place. There is a "mock" QAR on file which was conducted in April of 1999. The results were put into a written format, but no plan has been developed specific to this school site. Results of the pre and post test are not used for school improvement. The school district did place an administrator on-site to address programmatic issues; however, that occurred only one month ago. CSC corporate office sent a team to the program to provide support, but they only assisted the non-educational program. No support has been provided to the educational program.	The assistant principal is working with the school district to accomplish this plan.	R. Cunningham	8-2-99	
14.19	The school district makes all of its	See 14.15	R. Cunningham		

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
Partial	regular in-service offerings available to certified teachers on a first come, first serve basis. However, because of teaching schedules, lack of substitutes, time constraints, program location, and a large student population, teachers cannot typically attend these professional offerings. Moreover, new teachers and teachers who have Statements of Eligibility are excluded from these offerings despite statements of inclusion in the cooperative agreement. Interviews with teachers indicated that they had received little or no training while at the program. Teachers stated that they would like the opportunity to attend training that addresses ESE issues, varied instructional techniques, block scheduling, and behavior management.				
14.20 Partial	There is a cooperative agreement; however, it is not a working document. No complete budget was provided. There is documentation of state and district wide assessment results; however, this information is not in the student files. There was a school calendar available. Class schedules reflected 300 minutes of scheduled	A new schedule has been developed and approved that includes the time needed for teachers.	R. Cunningham	7-28-99	

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	class time, but this is not the actual time students receive instruction. Observations revealed that students regularly arrive late to class and leave early because of the lack of facility staff support. There is daily planning time for instructional personnel; however, there is no down time within the educational program that allows for program evaluation, planning and teacher training.				
14.21 N/P	The present number of 26 instructional staff is not adequate to serve 348 students. There is no evidence of educational support staff. There is very limited technology available for instructional staff. Much of the instructional materials is outdated and does not match student levels and abilities. Teachers are developing individual materials and often spend their own money on instructional supplies. There are not enough textbooks and very few instructional materials and supplies. There are limited media materials and there is no internet access available. There is only one computer lab with 12 computers in the facility. Moreover, this limited number of computers is not	There is a budget for the education department. Most of this is to be addressed in the contract with the district. With the split schedule the classroom space will be adequate. Team building is being done through the education department and activities for all staff to break the adversarial attitude The first order for instructional supplies was on 8-3-99 and then monthly after that.	R. Cunningham		

QA Standard	Deficiency	Action Plan	Person Responsible	Date Started	Date Completed
	capable of running much needed educational software. Classrooms are small and the space is not suitable for some classes. In addition, the environment is not conducive to learning due to the adversarial relationships.				